TENNESSEE

PART C FINANCE SYSTEM REVIEW

TASK FORCE

Final Report

August 09, 2005

Introduction

In 1986, Congress passed Public Law 99-457, the Individuals with Disabilities Education Act (IDEA), which included Part H (now Part C) that provided funds for States[1] to provide a statewide, coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers with disabilities and their families. One of the purposes of the early intervention program was to "facilitate the coordination of payment for early intervention services from Federal, State, local, and private sources (including public and private insurance coverage" (CFR §303.1(b)). The legislation required the Governor of each State to appoint a lead agency to administer the program. In that same year, Governor Lamar Alexander named the Department of Education (Department) as the lead agency for the Tennessee Early Intervention System (TEIS) and appointed a State Interagency Coordinating Council (SICC).

In planning and implementing the early intervention program, Tennessee adopted a moderately-restrictive definition of eligibility.[2] Tennessee also chose to provide services at no charge to families even though the Part C regulations allowed for a system of payment by families which could include a sliding fee (See CFR §§CFR 303.520 and 303.521).

On December 1, 2003, Tennessee was providing early intervention services to 4254 infants and toddlers and their families under this program. For FY 2003-04 the program was supported by $8,149,088 in federal funds and $13,507,700 in funds through the Department of Education ($7,264,900 appropriated to TEIS and $6,242,800 appropriated to the Tennessee Infant Parent Services (TIPS) School, a direct service program administered by the Department).

Since 1986, TEIS has enjoyed a cooperative working relationship with other agencies involved in the provision of early intervention services and TEIS has utilized appropriate services supported by or administered by other State departments and private entities. In 2004, however, it became increasingly clear that the cost of delivering early intervention services to the eligible population was quickly becoming more than the Department of Education's allocation of federal and State funds to support the program, and TEIS often had difficulties accessing supports or services from other programs in the service delivery system. It was also clear that the State's fiscal resources would be stretched even more by several factors including, but not necessarily limited to, (a) the requirement in IDEA 2004 that all children "involved in a substantiated case of child abuse or neglect or identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal drug exposure" (See Section 637(a)(6) of IDEA 2004) be referred for early intervention services, (b) the necessity of responding to recent Office of Special Education Programs' (OSEP) compliance findings regarding meeting the 45-day

[1] For the purposes of this report, State means the 50 States, District of Columbia, Puerto Rico and four jurisdictions that receive funds under this program.

[2] Tennessee's eligibility definition is a delay of 25% delay in two or more areas or 40% in one area of development. According to the Office of Special Education Programs, only eight (8) States have definitions classified as narrow: Alaska, Arizona, District of Columbia, Missouri, Montana, Nevada, North Dakota, and Oklahoma. See www.monitoringcenter.lsuhsc.edu/Stateranks-C

requirements for conducting a comprehensive evaluation and meeting to develop the Individualized Family Service Plan[3] and (c) the smaller federal allocation of funds.

Purposes, Membership and Organization of the Task Force

In light of these issues, the Department decided to establish a Financial Task Force (Task Force) to conduct a full review of the current financial structure and support for the Part C system, to determine if changes in the service delivery system would result in better utilization of fiscal resources, to examine child find and eligibility structures to ensure maximum efficiency and to develop recommended strategic changes needed to ensure the long term viability of this critical system of supports to our State's infants and toddlers with disabilities and their families. Specifically, the task force's responsibilities included:

- reviewing the function of each current and potential funding source;
- examining data on current expenditures for eligible children;
- developing trend reports and projections for future funding structures;
- identifying areas where programmatic and fiscal changes are necessary to support the program;
- identifying other State initiatives that have a direct relationship to support of the system; and
- recommending changes in policies and funding structure to improve and maintain the State's service delivery system.

Membership on the task force included representatives from the State Interagency Coordinating Council (SICC), State agencies and programs that provide support or services to young children with disabilities and their families, parents, private providers of early intervention services, and others as appropriate. A complete listing of the members of the Task Force can be found in Appendix A. The Task Force met from September, 2004 through May, 2005 to complete its work.

After reviewing and hearing reports from programs providing services to infants and toddlers with disabilities and their families, the Task Force members were subdivided into three subcommittees in order to more efficiently fulfill the purposes of the Task Force. The three subcommittees were Child Find and Eligibility, Finance and Service Delivery. The subcommittees were presented a list of possible research issues as a springboard from which the subcommittee could select issues with the most impact.

Child Find and Eligibility

- Examine the current Part C public awareness and child find procedures to determine effectiveness and comprehensiveness
- Investigate the extent to which the Part C procedures are consistent with but not duplicative of other major efforts to locate and identify infants and toddlers in need of early intervention services

[3]See http://www.OfficeofSpecialEducationPrograms/Monitoring/PartCVerificationLetters/Tennessee

- Examine the feasibility of establishing a common intake mechanism to be used by all State agencies providing early intervention services to the eligible population
- Identify current barriers to infants and toddlers being located and identified as needing early intervention services
- Outline the effects of the new Part C requirements (i.e., CAPTA and children affected by drugs) on the number of children potentially eligible for services and the projected cost to the system
- Research methods of determining the anticipated number of infants and toddlers in the State eligible for services under the current (or projected) eligibility criteria
- Research the system's growth trends and project numbers of infants and toddlers across districts, counties and statewide and compare with the projected eligibility numbers across the same geographical areas, and
- Examine and recommend strategies to ensure the eligibility evaluations meet federal requirements, are conducted in a timely manner and do not duplicate other evaluation efforts.

Finance

- Examine the pros and cons of the State instituting a system of payment including
  - use of a sliding fee
  - use of private insurance
- Research strategies for better utilization of TennCare/Medicaid funds
- Outline language for private insurance legislation, if Committee deems appropriate
- Examine array of services supported under the EI system to determine if non-required or duplicative services are being supported
- Develop strategies to ensure services will be supported in natural environments by all payors, and
- Research the feasibility of the State implementing a Central Billing system.

Service Delivery

- Examine the State's provision of early intervention services to determine the model(s) of service delivery currently being used and, as appropriate, recommend a model for statewide service delivery
- Determine if similar services designed to produce the same outcome(s) are being provided under different service names. As appropriate, the Committee could develop strategies, including service definitions, to eliminate duplication
- Study other State's service guidelines and determine the appropriateness of TEIS developing such guidelines

- Review the State's model for service coordination and outline any changes which could make service coordination more effective, and
- Examine other State initiatives providing services and determine how TEIS can best coordinate with those efforts.

Task Force Recommendations

After careful study by each subcommittee, the committees reported back to the committee to the entire Task Force for discussion and concurrence. A list of the recommendations receiving endorsement from the Task Force is presented below followed by a short discussion of each.

Child Find and Eligibility

- The State should develop a list of diagnosed physical or mental conditions that have a high probability of resulting in developmental delays (See CFR §303.16(a)(2)).
- The State should develop and implement a specific plan for a homeless initiative which includes State and local coordinators.
- The State should require each TEIS office to designate a coordinator to work with non-English speaking families and children.
- Each TEIS office should have a child find-screening coordinator.
- The State should develop a marketing plan and public awareness materials and implement a consistent ***statewide*** public awareness campaign designed to ensure that all eligible infants and toddlers are identified for services.
- The State should explore the use of a scientific model for estimating the number of children potentially eligible for TEIS services on an annual basis.

Funding

- The State should implement a Central Reimbursement Office (CRO) to ensure implementation of the "payor of last resort" requirement (See CFR §303.527), to ensure an accountable contract and payment system, maximize access to all payment sources, coordinate effective use of resources, reduce duplication, and strengthen communication with parents and providers.
- The State should institute a system of family cost participation which should include a sliding fee scale and maximum use of public and private insurance.
- The Department of Education should work with the Department of Commerce and Insurance to collaborate with insurers to explore State legislation to guarantee coverage of early intervention services by health insurance policies that would "cap" the extent of liability of the insurance providers.

Service Delivery

- The State should develop strategies to ensure continued movement of the system of early intervention services in the direction of helping families nurture their child's development in the context of daily routines that are fundamental to the life of a child, thus, ensuring services in natural environments. One of the strategies is to create a network of resources and ongoing technical assistance to support programs that incorporate this approach.
- The State should ensure a continuum of service options, resources and supports available to address individual child and family needs. The State should ensure that all programs and providers participate in the early intervention data system.
- The State should develop a compendium of developmentally appropriate practices which would provide the Individual Family Service Plan team with information to aid in determining the frequency, intensity, and duration of services to children and families. The State should monitor adherence to the developmentally appropriate service guidelines.
- The State should establish a Training/Technical Assistance Task Force to consider training and technical assistance needs related to system implementation.

Discussion of Individual Recommendations

Recommendation 1: The State should develop a list of diagnosed physical or mental conditions that have a high probability of resulting in developmental delays (See CFR §303.16(a)(2)).

The federal regulations specify that "infants and toddlers with disabilities means individuals from birth through age two who need early intervention services because they – (1) Are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas: (i) Cognitive development. (ii) Physical development, including vision and hearing. (iii) Communication development. (iv) Social or emotional development. (v) Adaptive development; or (2) Have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay." (See CFR 303.16(a)). Tennessee's current guidelines for the level of developmental delays for eligibility is 25% delay in two or more areas of development or 40% delay in one area of development. Even though Tennessee currently has a general list of conditions with examples (i.e., genetic syndromes such as Down Syndrome), the State has never had a specific diagnostic list of physical or mental conditions that could make a child eligible for services under TEIS.

The subcommittee examined eligibility information from all 56 States and territories participating in the Part C program. In addition, the subcommittee considered the trends from recently developed evaluation and assessment tools to determine the most appropriate method of describing the level of delay. Assessment and evaluation tools

appear to be moving away from using a percentage score and are moving toward utilization of a standard deviation or developmental quotient. As a result of these examinations, the subcommittee recommends the State make two changes in their eligibility criteria:

1. The State should develop a detailed diagnostic condition list to help clarify eligibility for physical and mental conditions that have a high probability of resulting in developmental delays. The subcommittee encouraged the State to carefully consider the diagnostic list currently used in Utah with a revision to replace category 17 with Tennessee's Prematurity Guidelines. The subcommittee felt that this change would add clarification and consistency across TEIS offices and with the medical community. In addition, specific diagnostic conditions could be captured in the data system currently being developed by the State. This data, when available, would allow for projections of numbers of children over time through prevalence of conditions.

2. The State should develop guidance information to assist persons conducting eligibility evaluations in determining if infants and toddlers meet the current eligibility criteria. The guidance information should allow eligibility based on a -1.5 standard deviation delay in two developmental domains or a -2.0 standard deviation delay in one developmental domain or a developmental quotient of 77.5 or below in two domains or a developmental quotient of 70 or below in one domain in addition to the percentages stated in the States current eligibility criteria.

Recommendation 2: The State should develop and implement a specific plan for a homeless initiative which includes State and local coordinators.

Part C of IDEA 2004 has placed a greater emphasis on child find for underserved populations of infants and toddlers. The Act specifically addresses homeless children (See sections 634(1), section 635(a)(2), and 641(b)(1)(K) of the Act). In an effort to better understand what is currently happening in the Department regarding homeless children, the subcommittee reviewed the McKinney-Vento Homeless Act, the Tennessee State Plan for Education of Homeless Children and Youth, and IDEA 2004.

After careful review of the above documents, the subcommittee recommended that TEIS should have a specific plan for a homeless initiative which would include State and local coordinators. The subcommittee suggested that the Department integrate Part C into the Tennessee Plan for Education of Homeless Children and Youth. One possible strategy for accomplishing this is to designate one staff person in each TEIS office as the local homeless coordinator in addition to serving as an ongoing service coordinator. In addition, one State staff person should be designated as the state-level coordinator to work with personnel implementing the education plan for homeless children. The committee felt that this is a potential compliance problem since there are probably infants and toddlers that are homeless and in need of early intervention services that have not currently been identified.

Recommendation 3: The State should require each TEIS office to designate a coordinator to work with non-English speaking families and children.

The subcommittee reviewed IDEA 2004, considering its emphasis on child find activities targeted to children from underrepresented populations and the August 12, 2004 Annual Performance Report letter from OSEP to the Department discussing OSEP's request for information on the location of various cultural/language groups and the impact of outreach activities on child find for these children. The subcommittee expressed concern about inconsistencies across the State in working with non-English speaking families.

The subcommittee recommended that one service coordinator in each TEIS office serve as a coordinator for non-English speaking families. The committee stated that this practice would provide for consistency across the State and for increased coordination for these families. This would be especially helpful in that one service coordinator would be knowledgeable about specific programs and services available to assist the various language groups within the district and to ensure program compliance.

Recommendation 4: Each TEIS office should have a child find-screening coordinator.

IDEA 2004 added requirements that each child under the age of 3 who is involved in a substantiated case of child abuse or neglect[4] (called CAPTA children) or is identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal drug exposure would be required to be referred for early intervention services. The Congressional conference report[5], however, makes clear that all these children should be screened by an early intervention service provider to determine whether a referral for an evaluation for early intervention is warranted. Research indicates there is a high rate of incidence of developmental delay in this population – perhaps as high as 40% of these children have speech/language problems, are developmentally delayed or have a learning disability.

While it is not known the impact of the referral of children affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure, 2542 children under the age of 3 in Tennessee were indicated as CAPTA children during the last fiscal year. Even though some of the CAPTA children may be able to be screened by the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, it is not clear that drug affected children will be eligible for screening through EPSDT or services through TennCare. Even if children can be screened by EPSDT, those results may not be available in a timely manner that will allow TEIS to meet the 45- day timeline for completing an evaluation and meeting to develop the IFSP, an issue of non-compliance identified by OSEP (see discussion on page 1 of the report). The cost of screening this volume of infants and toddlers will create an additional burden on the early intervention system, especially if the screening must be contracted through private providers. There will be additional costs to the system in completing comprehensive evaluations and the provision of services to these children.

[4] A similar provision had already been included in the Child Abuse Prevention and Treatment Act (CAPTA) as amended in June 2003 by the Keeping Children and Families Safe Act of 2003.
[5] Conf. Rpt. P.L. 108-446

The subcommittee, therefore, recommended there be a child find coordinator in each TEIS office. This person's responsibilities would include coordinating screenings with other agencies and/or completing screenings when necessary. The screening coordinator could, as time permits, also participate in completing appropriate eligibility evaluations on any referral, thus, saving the cost of contracting with provide providers.

Recommendation 5: The State should develop a marketing plan with public awareness materials and implement a consistent ***statewide*** public awareness campaign designed to ensure that all eligible infants and toddlers are identified for services.

The child find subcommittee examined national data and current trends indicating the number of children being served. The subcommittee also considered the OSEP's emphasis in the Continuous Improvement and Focused Monitoring System (CIFMS) on State's locating and serving all appropriate children. One phase of CIFMS is focusing OSEP's intervention on States with low-ranking performance on critical performance indicators.[6] One of the critical performance indicators is number of children served and numbered of children served under the age of one year. The national data[7] indicates that in 2003, Tennessee served 1.81% of children below the age of three while 2.23% were being served nationwide. Even when compared with other States with a moderate definition of eligibility, Tennessee ranked 9th of 16 States (range 4.42 to 1.04).

Based on this information, the subcommittee concluded the State may not be locating all appropriate children. In considering how to ensure that all eligible children are located and provided services, the committee recommended a coordinated, consistent *statewide* public awareness campaign. The subcommittee suggested that a marketing plan and materials be developed to be consistent across all nine districts. The subcommittee suggested that special tools and strategies could include website links to appropriate sites (i.e., Tennessee Pathfinders), utilizing marketing interns from Universities to assist each office, and developing public service announcements for television, radio and newspapers. A statewide campaign could reallocate local TEIS funds to the State effort and eliminate some costs due to current duplication of efforts across nine districts and between departmental programs. A State public awareness effort could link better than local TEIS offices with other state-level efforts.

Recommendation 6: The State should explore the annual use of a scientific model for estimating the number of children potentially eligible for TEIS services.

The current fiscal condition of early intervention in the State is a clear indication that the system needs a method of projecting over time the number of children potentially eligible for service so that a more accurate estimate of costs can be determined. At this time, Tennessee does not current use a scientific model for estimating the number of eligible children for the program. The subcommittee concluded that using a scientific model (such as the work conducted by Dr. Colleen Boyle) would assist in both a planning and budgeting tool. The use of a scientific model based on epidemiological data could provide State specific information for planning rather than relying on general disability research data that does not account for onset for some specific conditions and may not, therefore, reflect an accurate estimate for the birth through two age group.

---

[6] www.nectas.unc.ecu/topics/CIFMS

[7] www.monitoringcenter.lsuhsc.edu/stateranks-C

Recommendation 7: The State should implement a Central Reimbursement Office (CRO) to ensure implementation of the "payor of last resort" requirement (See CFR §303.527), to ensure an accountable contract and payment system, maximize access to all payment sources, coordinate effective use of resources, reduce duplication, and strengthen communication with parents and providers.

In considering how TEIS could change its administrative structure to create a more efficient management system, the Task Force was provided information about the effectiveness of creating a Central Reimbursement Office (CRO). The finance subcommittee specifically examined information from states with CRO (sometimes called Central Billing Offices or other similar names), and consulted with Maureen Greer, who was instrumental in the creation of Indiana's CRO, the first of its type in the nation, and who has consulted with most, if not all States that currently has this type of program. The subcommittee examined data regarding consistency of reimbursement procedures from the many State and local providers of services and identified gaps across the State regarding reimbursement procedures. The subcommittee also examined the burden placed on local service coordinators in assisting families with accessing resources to support payment for services and filing appropriate paperwork with the various agencies that support/provide services.

A CRO[8] is designed to receive and dispense all relevant /state and Federal resources for early intervention services. The CRO pays service providers from a revolving fund as bills are submitted and then bills the appropriate state agency for reimbursement. Information is obtained from families that indicate eligibility for various services. The CRO pays for appropriate services and satisfies all reporting requirements to the state funding sources pursuant to interagency agreements.

The functions of the CRO are:

- Track and report all resources used for early intervention services**.**
- Receive and dispense all relevant State and Federal early intervention resources**.** A comprehensive system is established to maximize all resources.
- Provide timely reimbursement to providers of early intervention services**.** The IFSP is the authorizing document for EI services. Certain information from the IFSP is electronically transmitted to the CRO, providing identifying information for the child and family in addition to service and funding information. The CRO generates a purchase order or electronic approval to initiate services. The purchase order is sent to the provider of each individual service listed in the IFSP. Providers enter data as services are utilized so that payment can be generated.

[8] This information is from Indiana and can be found at the following website: www.nectas.unc.edu/topics/finance/promising practices/centralized billing/Indiana

- Meet financial and demographic reporting needs of Federal, State and Local funding sources**.** Since all resources used to fund early intervention services are tracked by the CRO electronically, the system is set up to meet the specific reporting needs of all funding sources to ensure fiscal accountability, appropriate use of funds and the child or family's eligibility for services through various funds.

- Manage the level of resources to ensure fiscal accountability and responsibility**.** A system of authorizing transactions based on the IFSP provides the assurance to providers that funds have been allocated for payment of bills. The process includes analysis of planned levels of service to actual units of service delivered and is the source of information necessary to identify cash requirements to pay bills in a timely fashion. Monitoring of the authorized levels of service and projected expenditure level also assists the lead agency in identifying any impending shortfalls in advance, so that appropriate action can be taken.

- Provide on-line access to information using appropriate safeguards to assure confidentiality and protect the rights of the child and family**.** With informed, written parental consent, the CRO becomes the central point of electronic data collection and record maintenance for children and families participating in the EI system. The CRO creates and manages a single early intervention record, provides the opportunity for a single application for multiple financing, and ensures easy transfer of service and financing information as families or children move through the state. No additional financial or demographic data is required of providers or families.

- Provide financial projections on the cost of early intervention. The electronic data system allows data to be available to local service areas and state agencies to assist in planning activities. These data do not include confidential data, but data that help identify such issues as utilization of IFSP services, unmet needs, capacity building needs at the local level, and statewide recruitment and training needs.

A CRO is currently being utilized in several States. All of these States report a more efficient management system. Even though the CRO database would require some changes to make it appropriate for use in Tennessee, the software for a CRO is available at no cost from Indiana and the early intervention data base currently being developed would provide the necessary data for implementation.

Recommendation 8: The State should institute a system of family cost participation to include a sliding fee scale and maximum use of public and private insurance.

34 CFR 303.521(a) specifies that a State may establish a system of payment for early intervention services, including a schedule of sliding fees. Family cost participation is generally defined as any approach a States utilizes that involves a family's personal

resources in the payment of early intervention services. This may be either by the use of private insurance, developing a family fee system or both.

The finance subcommittee examined the current financial and service trends in Tennessee, including the available funds, both State and federal, and the costs of services. The committee also reviewed information from other States with a variety of finance systems including family cost participation such a sliding fee scales and mandated use of insurance. The subcommittee reviewed the current federal regulations regarding system of payments to determine permissible policies for cost participation.

The subcommittee concluded that the use of some form of family cost participation is fairly common nationwide. As of October 2003, 31 of 35 States participating in a national survey [9] reported using family cost participation for some, if not all, IFSP services. Eleven of those States reported both insurance utilization and family fees to support the provision of early intervention services. The States further reported that the typical driving force for utilizing family cost participation to support the provision of early intervention services was State budgets, legislative directives, lead agency decisions, an interest in bringing family ownership to the IFSP process and a combination of other reasons.

Due to the current financial situation impacting on early intervention in Tennessee, the Task Force recommended immediately instituting a system of family cost participation to include a sliding fee scale and mandating the use of public and private insurance to support the provision of services. These revenue sources are the only ones allowable under federal guidelines that are currently not being used in the State. With the data available to the subcommittee, it was impossible to estimate the amount of funds which would be generated as a result of implementing a system of payment that includes family cost participation but, in isolation, probably would not be sufficient to eliminate current deficits and accommodate the growing numbers of children to be served in the program.

Recommendation 9: The Department of Education should work with the Department of Commerce and Insurance to collaborate with insurers to explore State legislation to guarantee coverage of early intervention services by health insurance policies that would "cap" the extent of liability of the insurance providers.

One of the stated purposes of Part C of IDEA is to "facilitate the coordination of payment for early intervention services from Federal, State, local, and private sources (including public and private insurance coverage)". See CFR §303.1(b). Since Tennessee currently has a "no cost to family" system, private insurance can only be utilized as a source of support for early intervention services if parents provide permission for its use as is the policy in several other States. The results of an Infant & Toddler Association survey identified eight States (AK, FL, GA, ID, IL, MA, SC and VA) that required the parent to consent to the use of the family's private insurance for Part C covered services. At least five States (CT, IL, IN, MA, VA) have state-specific insurance legislation that, while the coverage varies by individual State, requires coverage of early intervention services contained in the child's IFSP. Most of these insurance statutes exempt the cost of early

[9] "Part C System of Payments: Family Cost Participation", IDEA Infant & Toddler Association.

intervention services from any lifetime benefit cap for the child or family and "cap" the insurance liability to a maximum amount of between $3500 and $5000 per child.

Recommendation 10: The State should develop strategies to ensure continued movement of the system of early intervention services in the direction of helping families nurture their child's development in the context of daily routines that are fundamental to the life of a child, thus, ensuring services in natural environments. One of the strategies is to create a network of resources and ongoing technical assistance to support programs to incorporate this approach.

Federal regulations require that, "to the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate" CFR §303.12(b). The December 2003[10] child data indicated that Tennessee served 70% of the infants and toddlers in home settings; only 10 States served a smaller percentage. At that same time, Tennessee served 5.97% in programs for typically developing children which was 21st in the nation and above the national average of 3.59%. However, Tennessee was serving 19% in service provider locations; only two States served more children in service provider locations. When all service provision location data are aggregated across settings, the national data indicates that only 11 States served a smaller percentage of children in natural environments than Tennessee.

The service delivery subcommittee considered these data, research findings and best practice literature and recommended that the State should strengthen current efforts to ensure services are provided in the context of daily routines of families. The subcommittee recommended the State create a network of resources and ongoing technical to support programs to incorporate a natural environment approach.

Recommendation 11: The State should ensure a continuum of service options, resources and supports available to address individual child and family needs. The State should ensure that all programs and providers participate in the early intervention data system.

Even though the regulations require that "to the extent appropriate", children must be provided services in settings where children without disabilities participate, there may be children that require services in more restrictive settings. As a result, many programs across the State provide a range of service options – from home and community settings to center-based (either with non-delayed children or only with children with delays). While it is important to ensure the availability of options of services in order to meet the needs of all children, having a plethora of service options, often with services of various titles designed to produce similar outcomes, can lead to duplication of services and more intrusion in the child and family's life. Therefore, the service delivery subcommittee recommended that the State ensure a continuum of services, resources and supports available to address child and family needs, but develop strategies to ensure duplicative services are not provided to children and families. In addition, in order to better monitor and ensure accuracy of data, the subcommittee recommended that all programs and

[10] www.ideadata.org

providers be required to participate in the early intervention data system currently under development.

Recommendation 12: The State should develop a compendium of developmentally appropriate practices which would provide the Individual Family Service Plan team with information to aid in determining the frequency, intensity, and duration of services to children and families. The State should monitor adherence to the developmentally appropriate service guidelines.

The service delivery subcommittee studied the types and amounts of services being provided in Tennessee. The subcommittee also reviewed research, best practice literature, OSEP service definitions, and information from other States regarding how to determine how much service is appropriate for an infant or toddler. The literature review emphasized that "more is not always better" (meaning more services/therapies do not necessarily equal or result in better service, developmental growth, or the accomplishment of functional outcomes). Learning opportunities need to be made available within the child and family's natural daily routines.

Many States have developed Service Guidelines in an effort to assist IFSP teams and service providers in determining the amount and intensity of developmentally-appropriate services. These guidelines generally consider the age, condition, severity, etc and provide guidance as to what service delivery would be developmentally appropriate and have a high probability of producing positive developmental outcomes.

The subcommittee recommended that the State establish a task force of stakeholders to work in conjunction with the lead agency to develop a compendium of developmentally-appropriate practices - parameters which give appropriate guidance under which program planners, acting collectively, can operate in order to address needs and equitably provide service, and at the same time be responsible in the application of fiscal resources. The practices document should provide service definitions to ensure consistent terminology across programs, thus helping to reduce or eliminate duplication of services. The State should develop a system of review to determine the extent to which guidelines are being following and identify changes that need to be made in the guidelines.

Recommendation 13: The State should establish a Training/Technical Assistance Task Force to consider training and technical assistance needs relating to system implementation.

The service delivery subcommittee reviewed the best practice literature, the services issues facing service providers in the State at this time and the changes which would have to be made in order to be fiscally sound, and suggested the State establish a Training/Technical Assistance Task Force to address the needs of providers and parents as changes are implemented. The subcommittee suggested several areas that should be considered by the Task Force: best practices in natural environment, using coaching model/consultative therapies, how to increase learning hours rather than hours in intervention, how to develop functional child outcomes and result-based programming.

SUMMARY

The Financial Task Force considered many aspects of the early intervention system and has formulated 13 recommendations for consideration of the Department of Education, the lead agency for the provision of early intervention services. Some of the recommendations can be implemented quickly and with little cost such as a standardized list of conditions and syndromes (see recommendation #1); other recommendations, such as the establishment of a Central Reimbursement Office (see recommendation # 7) will require extensive planning and some funding to implement. Many of the recommendations could be implemented within a State fiscal year if funds and staff are dedicated to the effort. All recommendations should be carefully considered by the Department. Members of the Task Force will be available to discuss these recommendations and provide more information to the Department if requested.